Department of Health
Office of EMS & Trauma System
PO Box 47853
Olympia, WA 98504-7853
360.236.2828

Application Packet for Initial Certification & Recertification of EMS Providers

Contents:

Important Social Security Number Information:

Social Security Number: You are required by state and federal law to provide a social security number with your application. If you do not have a social security number at the time you send in this application, please contact customer service 360.236.4700 for more information.

A U.S. Individual Taxpayer Identification Number (ITIN) or a Canadian Social Insurance Number (SIN) cannot be substituted.

In order to process your request:

Return Completed Applications and documents to:

Office of Emergency Medical Services & Trauma System
P.O. Box 47853
Olympia, WA 98504-7853
For questions call:
360.236.2840
800.458.5281 x 2

Introduction

Your certification is a personal property right, and as such, may be removed through “due process” for violations of the Uniform Disciplinary Act (UDA), **RCW 18.130**. When you are applying for certification, it is critical that you complete the application yourself, and that you answer all questions accurately. Please do not alter the Personal Data Questions part of the application. An altered, incomplete, or incorrectly completed application cannot be processed and will delay your possible certification.

Include this blank page when printing two-sided.
Do **not** remove.

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General Instruction Checklist

Required Documents:

Initial certification applicants must provide a copy of a Department of Health course completion certificate for the level which they are applying (Initial/upgrade applicants only.)

If applying for initial paramedic certification, you must also provide a copy of your National Registry Certificate.

Check Appropriate Box: Initial, Upgrade, Reversion, Recertification, or Reinstatement.

- **Initial:** Completed a Washington State DOH-approved course and applying for certification for the first time.
- **Upgrade:** Currently a certified EMS provider who has completed a higher level EMS course in Washington State and is now applying for a higher level of certification.
- **Reversion:** Currently a certified EMS provider who wants to revert to a lower EMS level.
- **Recertification:** Currently a certified EMS provider who is recertifying at the same EMS level.
- **Reinstatement:** Washington certification has been expired for 36-months or less, applying to reinstate certification. If your certification has been expired for more than 36 months contact the OEMSTS for instructions. (36 months does not apply to paramedics) http://www.doh.wa.gov/hsqa/emstrauma/reinstat.htm

☐ **#1: Demographic Information:**
Social Security Number: You **must** list your social security number on your application. Please call the Customer Service Center at 360.236.4700 if you do not have one.
Name: List your full name with first, middle, and last.
Birth date: Provide the city, state, and country you were born in.
Address: List the address we should use to send any information on your credential. Be sure to include the city, state, zip code, and country. This will be your permanent record with Department of Health. You can ask us to change it. See WAC 246-12-310.
Phone, Fax, and Cell Numbers: Enter your phone, fax, and cell numbers.
Email: Enter your email address, if you have one.
Other Name(s): Indicate whether you are known or have been known under any other names. If you have a name change, you must notify the Department of Health in writing. You must include proof of this change. See WAC 246-12-300.

☐ **#2: Personal Data Questions:**
All applicants for certification are required to answer all personal data questions. These are narrowly focused on your fitness to practice the essential skills of this profession.

If you answer "yes" to any questions in this section, you must provide an appropriate explanation and the documentation listed in the note following the question. If you do not provide the documents, your application is incomplete and will not be processed.

- Question 5 includes misdemeanors, gross misdemeanors and felonies. You do not have to answer yes if you have been cited for traffic infractions. You can obtain copies of court records through the county courthouse where the conviction, plea, deferred sentence, or suspended sentence was entered.
- For question 5, you must answer yes if you were convicted as either a juvenile or an adult. "Another jurisdiction" means any other country, state, federal territory, or military authority.

General Instruction Checklist Cont.

☐ **#3: Certification Level Applying for:**
Indicate the level of certification you are requesting at this time (choose only one).Choose either paid or volunteer to indicate your primary status with the EMS agency you are associated with. High school grad or GED required all levels except first responder.

☐ **#4: EMS Agency Association Requirement:**
Provide all of the information regarding your primary DOH licensed EMS agency. If you are not associated with an EMS agency licensed by the Washington State DOH, your application cannot be processed. Active association with a Washington State DOH licensed EMS agency is required for certification.

☐ **#5: Recertification Requirements Checklist: (Only complete if recertifying, reinstating, or reverting.)**
Choose the method you met your continuing medical education (CME) requirements for your last certification period. If you select “traditional CME”, you will need to take the Washington State written certification and practical exam. These are both required within 6 months prior to application. “OTEP” means an ongoing training and evaluation program, which is approved for specific EMS agencies by the Department of Health and County Medical Program Directors (MPD).

☐ **#6: EMS Agency Supervisor Statement:**
Your EMS agency supervisor must complete this portion of your application. **Note:** You cannot sign for yourself as supervisor. Please have your supervisor sign and date the application.

☐ **#7: Medical Program Director (MPD) Statement:**
Follow the instructions from your local EMS coordinator or EMS agency supervisor to obtain your MPD’s recommendation, signature and date. Your application is not complete until it is signed and dated by the MPD recommending you for certification.

☐ **#8: Applicant’s Attestation:**
You must print your name and read the statement thoroughly to ensure you understand the provisions in this section. Provide the date and the city you are in then sign the statement. This must be complete in order for us to process your application.

☐ **#9: Applicant’s Photograph:**
Attach to the application a current, legible photograph showing date of birth (DOB) ie., drivers’s license photo, passport, or military ID. The photograph must be clear and the information must be legible.

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Background Check Stamp Here

Date Stamp Here

Washington State EMS Initial or Recertification Application

Check Appropriate Box: ☐ Initial ☐ Reversion ☐ Reinstatement ☐ Upgrade ☐ Recertification

Please Type or Print Clearly—It is the responsibility of the applicant to submit or request to have submitted all required supporting documents. Failure to do so could result in a delay in processing your application. Make sure you have read and understand the instructions.

1. Demographic Information

Social Security Number (- -) (If you do not have a social security number, see instructions)

Name ☐ Male ☐ Female First Middle Last

Birth date (mm/dd/yyyy)	Place of Birth		
	City	State	Country

Address

City	State	Zip	County

Country

Phone	Fax	Cell

Email Address:

Mailing address (if different from above)

City	State	Zip	County

Country

NOTE: The mailing and email addresses you provide will be your addresses of record. It is your responsibility to maintain current contact information on file with the Department of Health.

Have you ever been known under any other name(s)? ☐ Yes ☐ No **Circle maiden name**

If yes, list name(s):

Will documents be received in another name? ☐ Yes ☐ No

If yes, list name(s):

For Office Use Only

Issuance Date _____ Credential# _____

Validation _____ Received Date _____

Check Appropriate Box: ☐ Initial ☐ Reversion ☐ Reinstatement
☐ Upgrade ☐ Recertification

The Certification Level I am Applying for is: (Please Select One)

☐ First responder ☐ EMT ☐ IV Tech ☐ Airway tech
☐ IV/Airway tech ☐ ILS tech ☐ ILS W/Airway ☐ Paramedic ☐ Poison information specialist

Personal Data Questions Instructions

Personal data questions must be completed by all applicants. Returned this form directly to the Department of Health to maintain confidentiality. Please follow the instructions below:

1. **Detach, review and complete pages 2 of 5 and 3 of 5 of the application. (This page and the next page) Make sure you provide accurate information.**
2. Attach appropriate additional information, and mail it to Office of EMS and Trauma System Licensing and Certification Section, PO Box 47853, Olympia, WA 98504-7853

Last Name _____ First Name _____ Middle _____

Address _____ City _____ State _____ Zip _____

Social Security Number (- -) _____ County of primary employment _____

2. Personal Data Questions

Yes No

1. Do you have a medical condition which in any way impairs or limits your ability to practice your profession with reasonable skill and safety? If yes, please attach explanation. ..... ☐ ☐

"Medical Condition" includes physiological, mental or psychological conditions or disorders, such as, but not limited to orthopedic, visual, speech, and hearing impairments, cerebral palsy, epilepsy, muscular dystrophy, multiple sclerosis, cancer, heart disease, diabetes, mental retardation, emotional or mental illness, specific learning disabilities, HIV disease, tuberculosis, drug addiction, and alcoholism.

If you answered yes to question 1, explain:

1a. How your treatment has reduced or eliminated the limitations caused by your medical condition.

1b. How your field of practice, the setting or manner of practice have reduced or eliminated the limitations caused by your medical condition.

Note: If you answered "yes" to question 1, the licensing authority will assess the nature, severity, and the duration of the risks associated with the ongoing medical condition and the ongoing treatment to determine whether your license should be restricted, conditions imposed, or no license issued.

2. Do you currently use chemical substance(s) in any way which impair or limit your ability to practice your profession with reasonable skill and safety? If yes, please explain. ..... ☐ ☐

"Currently" means within the past two years.

"Chemical substances" include alcohol, drugs, or medications, whether taken legally or illegally.

3. Have you ever been diagnosed with, or treated for, pedophilia, exhibitionism, voyeurism or frotteurism? ..... ☐ ☐

2. Personal Data Questions (Cont.)

Yes No

4. Are you currently engaged in the illegal use of controlled substances? ☐ ☐

"Currently" means within the past two years.

Illegal use of controlled substances is the use of controlled substances (e.g., heroin, cocaine) not obtained legally or taken according to the directions of a licensed health care practitioner.

Note: If you answer "yes" to any of the remaining questions, provide an explanation and certified copies of all judgments, decisions, orders, agreements and surrenders. The department does criminal background checks on all applicants.

5. Have you **ever** been convicted, entered a plea of guilty, no contest, or a similar plea, or had prosecution or a sentence deferred or suspended as an adult or juvenile, in Washington or another state or jurisdiction? ☐ ☐

Note: If you answered yes, you must send certified copies of all court documents related to your criminal history with your application. If you do not provide the documents, your application is incomplete and your application will not be considered.

To protect the public, the department considers criminal history. A criminal history may not automatically bar you from obtaining a credential. However, failure to report criminal history may result in extra cost to you and the application may be delayed or denied.

6. Have you ever been found in any civil, administrative or criminal proceeding to have:
   a. Possessed, used, prescribed for use, or distributed controlled substances or legend drugs in any way other than for legitimate or therapeutic purposes? ☐ ☐
   b. Diverted controlled substances or legend drugs? ☐ ☐
   c. Violated any drug law? ☐ ☐
   d. Prescribed controlled substances for yourself? ☐ ☐

7. Have you ever been found in any proceeding to have violated any state or federal law or rule regulating the practice of a health care profession? If "yes", please attach explanation and provide copies of all judgments, decisions, and agreements? ☐ ☐

8. Have you ever had any license, certificate, registration or other privilege to practice a health care profession denied, revoked, suspended, or restricted by a state, federal, or foreign authority? ☐ ☐

9. Have you ever surrendered a credential like those listed in number 8, in connection with or to avoid action by a state, federal, or foreign authority? ☐ ☐

10. Have you ever been named in any civil suit or suffered any civil judgment for incompetence, negligence, or malpractice in connection with the practice of a health care profession? ☐ ☐

11. Have you previously provided the Department of Health with information regarding any "yes" answers? ☐ ☐

Applicant Statement

I certify that the above information is true and correct.

_____ _____

Printed Name Phone Number

_____ _____

Signature Date

3. The Certification Level I am Applying for is: (Please Select One)

☐ First responder ☐ EMT ☐ IV Tech ☐ Airway tech
☐ IV/Airway tech ☐ ILS tech ☐ ILS W/Airway ☐ Paramedic ☐ Poison information specialist

1. Will you be primarily a "paid" or "volunteer" EMS provider? ..... ☐ Paid ☐ Volunteer
2. Have you earned a high school diploma or GED certificate? ..... ☐ Yes ☐ No
   (First responders exempt)

4. EMS Agency Association Requirement

Please provide the following information regarding your primary agency association:

Agency Name: _____

Address: _____

Phone Number: _____

EMS Contact Person: _____

Agency Credential Number: _____

If you are certified, will you continue to provide EMS care with this agency? ..... ☐ YES ☐ NO

5. Recertification Requirements

How have you met your continuing medical education (CME) requirements for the last certification period?

Please check **one:**

☐ Traditional CME (Requires DOH EMS certification exam)

-or-

☐ (OTEP) Ongoing training & evaluation program

ILS and ALS levels only - Have you successfully completed the skills maintenance requirements for your level of certification? ..... ☐ Yes ☐ No

6. EMS Agency Supervisor

"I affirm that if this applicant is certified, he/she will provide care with our EMS agency."

_____ _____ _____

Name of EMS Agency Supervisor (Please print) Original Signature Date

7. County Medical Program Director

The signature of the Washington State Medical Program Director (MPD) for the county where the applicant is providing care, or where his/her EMS agency is based, is required before state certification may be granted to this applicant.

☐ "I recommend certification ☐ I do not recommend certification (attach a memo for details) of this applicant based on the statements above, pending successful completion of the required examinations and/or evaluations. This applicant, if recommended for certification, has a copy of my county protocols." Protocol requirements do not apply to poison information specialists.

_____	_____	_____
County MPD's Printed Name	County MPD's Original Signature	Date

8. Applicant's Attestation

I, _____ , declare under penalty of perjury under the laws of the state
(print applicant name clearly)

of Washington that the following is true and correct:

- I am the person described and identified in this application.
- I have read **RCW 18.130.170** and RCW **RCW 18.130.180** of the Uniform Disciplinary Act.
- I have answered all questions truthfully and completely.
- The documentation provided in support of my application is accurate to the best of my knowledge.

I understand the Department of Health may require more information before deciding on my application. The department may independently check conviction records with state or federal databases.

I authorize the release of any files or records the department requires to process this application. This includes information from all hospitals, educational or other organizations, my references, and past and present employers and business and professional associates. It also includes information from federal, state, local or foreign government agencies.

I understand that I must inform the department of any past, current or future criminal charges or convictions. I will also inform the department of any physical or mental conditions that jeopardize my ability to provide quality health care. If requested, I will authorize my health providers to release to the department information on my health, including mental health and any substance abuse treatment.

Dated _____at _____ (city, state)

By: _____
Signature of Applicant

9. Applicant's Photograph

Attach to the application a current, legible photograph showing date of birth (DOB) ie., drivers's license photo, passport, or military ID. The photograph must be clear and the information must be legible.

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EMS and Trauma System Reference Numbers and Links

RCW and WAC Links

Uniform Disciplinary Act,
UDA RCW 18.130..... http://apps.leg.wa.gov/RCW/default.aspx?cite=18.130

Administrative Procedure Act,
APA RCW 34.05 ..... http://apps.leg.wa.gov/RCW/default.aspx?cite=34.05

Administrative procedures and requirements,
WAC 246-12 ..... http://apps.leg.wa.gov/WAC/default.aspx?cite=246-12

Emergency Medical Services and Trauma
System WAC 246-976 ..... http://apps.leg.wa.gov/WAC/default.aspx?cite=246-976